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ABSTRACT

This report was written by the General Accounting Office (GAO) in response to a request by Senator John Melcher that the GAO provide information about prescription drugs as they relate to the needs of the elderly. The information in the report is based on results of an ongoing GAO study of catastrophic illness insurance and is derived from documents which the GAO has reviewed and from two legislative proposals to expand Medicare coverage for catastrophic illness. Demographic information about use and cost of prescription drugs is presented which shows that many of the elderly need prescription drugs but cannot afford to pay for them. Prescription drug coverage under Medicare, under Medicaid, and in states that have developed programs specifically to meet this need is discussed. Ways in which the House of Representatives and Senate bills (H.R. 2470 and S.1127) would provide benefits for prescription drugs for the elderly, and the groups of the population that would remain without benefits if these bills were enacted are examined. Tables illustrating state Medicaid coverage and state prescription drug programs are appended. (NB)

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Report to the Chairman, Special Committee on Aging, U.S. Senate

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July 1987

MEDICARE

Prescription Drug Issues

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United States
General Accounting Office
Washington, D.C. 20548

Program Evaluation and
Methodology Division

B-227664

July 16, 1987

The Honorable John Melcher
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

On July 14, 1987, you asked us for information about prescription drugs as they relate to the needs of the elderly. In particular, you were interested in the following questions:

1. To what extent do the elderly need and use prescription drugs and what are the costs to the elderly?

2. What prescription drug benefits, other than inpatient benefits, are covered under Medicare?

3. To what extent does Medicaid provide prescription drug benefits?

4. What states have separate programs to provide assistance to the elderly for prescription drugs? What kind of assistance do these programs provide and who benefits from them?

5. What provisions are included in H.R. 2470 and S. 1127 that pertain to prescription drug benefits and to what extent will these benefits meet the needs of the elderly?

Scope and Methodology

The information in this letter responds to these questions and is based, in part, upon the results of the ongoing study of catastrophic illness insurance that we are also performing at your request. Matters pertaining to prescription drugs will be only one small part of the larger study, on which we expect to issue a report to you at a later time.

Our information is for the most part derived from documents that we have reviewed, but which we have not independently verified, and from two legislative proposals to expand Medicare coverage for catastrophic illness: the House Ways and Means Committee bill H.R. 2470 as amended by the House Committee on Energy and Commerce and the Senate Finance Committee bill S. 1127, both entitled "The Medicare Catastrophic Loss Prevention Act of 1987."

We begin with demographic information about use and cost and then briefly discuss prescription drug coverage under Medicare, under Medicaid, and in states that have developed programs specifically to meet this need. We close with a discussion of how H.R. 2470 and S. 1127 would provide benefits for prescription drugs for the elderly and the groups of the population that would remain without benefits if these bills were enacted.

Use and Cost

That the cost of prescription drugs is rapidly rising is an important fact for the millions of the elderly suffering from diabetes, high blood pressure, various heart conditions, some types of cancer, and other conditions. They depend on medication to help control these problems, so that buying prescription drugs is a major out-of-pocket health-care expense for them.

More than 75 percent of the persons older than 65 in this country use prescription drugs; for the elderly who are chronically ill, this figure is 90 percent.

Persons 65 and older use 30 percent of all the prescription drugs used in the United States—approximately three times the rate of the population younger than 65.

For three of every four elderly persons, prescription drugs are the largest out-of-pocket health-care expense. A 1986 study commissioned by the American Association of Retired Persons (AARP) estimated that drug expenditures for persons 65 years old and older are $9 billion annually and that $7.3 billion of this is out-of-pocket expense.

From January 1980 through 1986, the cost of prescription drugs rose about 80 percent—two and a half times faster than the rise in consumer prices in general.

According to a report by the Public Health Service, 15.5 percent of the elderly patients who require prescriptions said they are unable to pay for their drugs. An AARP survey reported the cost of prescription drugs as an important reason why the elderly often do not get their prescriptions filled.

Medicare Coverage

Under current law, Medicare generally covers inpatient drugs but pays for outpatient drugs in only a few instances.

Outpatient prescription drugs are generally not covered by Medicare Part B, with the exception of drugs that require injection by a physician or nurse. Injections that patients commonly administer to themselves, like insulin, are in general not covered. (Self-administered drugs that must be administered by a physician or nurse in an emergency are covered, and so are blood-clotting factors for certain hemophilia patients.) Pills and other oral medications are excluded from Part B because they are self-administered.

Medicare does pay for outpatient use of immunosuppressant drugs (such as cyclosporine and cycloserine) in the first year following a Medicare-covered transplant operation.

The Congressional Budget Office (CBO) estimates that the costs of providing immunosuppressant drugs to 9,000 Medicare beneficiaries with organ transplants will approach $35 million in 1987, or about $4,000 per beneficiary.

Immunizations are covered only in specific circumstances: vaccination against pneumococcal pneumonia and hepatitis B (for those at medium or high risk only) and immunization directly related to the treatment of an injury or direct exposure to a disease or condition such as rabies or tetanus. Most immunizations, such as for smallpox and influenza, are not covered.

Medicare beneficiaries may enroll in health maintenance organizations (HMO's) and competitive medical plans that cover all Part A and Part B benefits and that may include prescription drugs. In most cases, the beneficiaries pay an additional premium for drugs and other benefits directly to the HMO or plan. In May 1987, the records showed 914,715 Medicare beneficiaries enrolled under "risk contracts" with 152 HMO's or plans. Outpatient drug benefits were offered by 115, or 76 percent, of the contractors.

Medicaid Coverage

Medicaid provides optional prescription drug coverage for the low-income elderly in most states. As shown in appendix I, all the states except Alaska and Wyoming reportedly provide some coverage. As indicated in the appendix, 10 states impose major restrictions on drug coverage.

According to the Health Care Financing Administration (HCFA), 2.2 million Medicare enrollees are covered by state Medicaid programs.

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Also according to HCFA, the 2.4 million recipients of drug benefits under Medicaid in fiscal year 1986 accounted for $972.6 million in expenditures.

Medicaid pays the lower of the cost of the ingredients of prescribed drugs plus a reasonable dispensing fee or a provider's usual and customary charge to the general public.

Some states may limit the benefits they will pay, requiring the recipient to pay any costs above an estimated acquisition cost—a state Medicaid agency's best estimate of the price that providers are generally paying for a prescribed drug.

Medicaid limits benefits for the cost of drugs—including generic drugs—marketed by two or more drug companies to the lower of the maximum allowable cost established by HCFA's pharmaceutical reimbursement board (and published in the Federal Register) or the estimated acquisition costs. A state may also establish its own list of maximum allowable costs. (The cost of a multiple-source drug is not limited by this list if the physician certifies in handwriting that, in his or her professional judgment, a specific brand is medically necessary for the patient.)

Of the 48 states with a prescription drug program under Medicaid, 22 charge recipient copayments, which range from $0.50 to $3.00.

State Medicaid agencies may place additional limits on benefits for prescription drugs, such as limits on the number of prescriptions that can be filled in a certain time period or limits on the quantity of each prescription that may be filled at one time.

Coverage Under State Programs

Nine states offer specific programs covering some drug benefits for portions of their populace: Connecticut, Delaware, Illinois, Maine, Maryland, New Jersey, New York, Pennsylvania, and Rhode Island. (See appendix II for the basic structure of these programs.) This means that 41 other states do not have such programs; even in the 9 states with programs, some portions of the population do not receive assistance in purchasing drugs because of eligibility requirements or copayments.

All 9 programs have an income level above which people are ineligible, and 8 have some copayment provisions. Some states set their income thresholds higher than others, thus allowing more people to participate.

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For example, New Jersey's level is $16,750 for couples, Connecticut's is $16,000, and Pennsylvania's is $15,000. Other states, such as Delaware, Maine, and Maryland, set their income eligibility relatively low, increasing the chance that the nearly poor will not receive benefits. Some states set copayment levels relatively low—$1 or $2 per prescription—and one program has an upper limit. Other states, such as New York and Rhode Island, set higher copayment levels (New York's sliding scale approximates a 40-percent copayment) in order to keep the costs of the program down and to create incentives for the recipients to seek the lowest drug prices and to use generic drugs.

Individuals receiving benefits as a percentage of the elderly population in a state range from 4 percent to 27 percent. This leaves a sizable number of elderly who do not benefit—as many as 96 percent in Illinois. Lack of participation may be because people need prescription drugs but do not meet the eligibility requirements or because they do not need the drugs covered by the programs. We do not know the proportions of the elderly that fall into either category.

Some of these programs have features that can be instructive for a federal program. For example, New Jersey, the first state to establish a program, has experienced considerable cost growth. The cost was $35 million in 1978, $70 million in 1984, and $96 million in 1986. An initially large cost doubled in 6 years and almost tripled in 8 years. In order to deal with this cost growth, New Jersey increased its copayment from $1 to $2, included a provision for prescribing generic drugs, set a maximum-allowable-cost provision, and tightened the residency requirements. The lesson is that precautions should be taken from the start.

In Maryland, eligibility is based on income and assets, not on age. Currently, 62 percent of the recipients are older than 64, 26 percent are between 64 and 45, and 12 percent are younger than 45. In other words, in a program that does not base eligibility restrictions on age, a sizable proportion of nonelderly individuals who have pharmaceutical needs will take advantage of benefits, if they are offered.

In Pennsylvania, copayments can go up or down, depending upon the actual costs of the drugs. Pennsylvania is concerned with rapid cost increases. In the first year, it paid out $62 million; in the second year, it paid out twice and in the third year three times that amount. To control its cost increases, the Pennsylvania program developed three forms of cost control: (1) it developed a review of the program's use, (2) it targeted various education projects to consumers, physicians, and

health and social services practitioners, and (3) it expanded its efforts to recover money from insurance companies (since the state is a "payer of last resort"). It is clear that cost control must be addressed.

Rhode Island designed its program intentionally to be what its director calls "conservative." Having examined the experience of some other states, particularly Pennsylvania, Rhode Island saw the need to create a small program that could function within limited budget constraints.

Coverage Under H.R. 2470 and S. 1127

On June 17, 1987, the House Committee on Energy and Commerce reported out an amended version of H.R. 2470 that would cover the cost of prescription drugs for Medicare beneficiaries. We discuss its scope below, as well as that of S. 1127.

The amended H.R. 2470 would expand Part B to include 80 percent of all reasonable costs for self-administered prescription drugs, insulin, and approved "biologicals" over a deductible amount. The deductible would be $500 for calendar year 1989 and indexed to the medical component of the consumer price index. The deductible and other expenses that enrollees incur for drugs would not count toward the bill's proposed $1,043 cap on out-of-pocket copayments for all services covered by Medicare.

Medicare beneficiaries are liable for 20 percent coinsurance for each prescription after the deductible has been met.

It is estimated that for the elderly, the 1988 annual per capita expenditure on prescription drugs would be $250 in 1988, $268 in 1989, and $331 in 1992. Further, it is estimated that 5.5 million, or 16.9 percent, of the Medicare Part B enrollees would exceed the $500 deductible on prescription drugs in 1989, at an estimated cost of $965 million.

CBO also indicates that the use of prescription drugs would rise only slightly under this proposal because of the large deductible and the fact that drug use is determined by physicians.

The new benefit would be financed entirely with a monthly premium that would be paid by all enrollees under Part B of Medicare, and the amount of this premium they would pay for drugs would increase $0.30 in 1988, $3.60 in 1989, $5.60 in 1990, $6.30 in 1991, and $6.80 in 1992.

However, the bill would require the states, through their Medicaid programs, to cover both the Medicare Part B premium (including any increment attributable to the prescription drug benefit) and the $500 deductible for all elderly and disabled Medicare beneficiaries whose incomes are below the federal poverty line and whose countable resources are no more than twice the level permitted by the Supplemental Security Income program ($3,600 in 1987).

The amended version of S. 1127 focuses directly on only immunosuppressant drugs for organ transplants. Broader coverage is to be determined at a later date. The relevant provisions would count the cost of immunosuppressant drug therapy toward the Medicare Part B copayment cap. Medicare now covers 80 percent of the cost of the first year of this therapy after an approved organ transplant operation, but patients must pay all costs thereafter.

The Senate bill also calls for a study by the Institute of Medicine to examine prescription drug use, costs, and coverage policy.

In summary, the addition of coverage for prescription drugs for Medicare enrollees under H.R. 2470 and S. 1127 would reduce their out-of-pocket expenditures. The reduction would be greater under H.R. 2470. However, the proposed deductible of $500 might limit the participation of the nearly poor, limiting the extent this provision would help them, particularly the elderly who do not have supplementary insurance under private coverage. The provision in H.R. 2470 that requires the states to cover through Medicaid the program costs for the elderly below the federal poverty level would provide protection for the poor.

Final Comment

We have reviewed the issue of prescription drugs from the perspectives of use and costs, and we have looked at proposed assistance to the elderly as they pay for their prescription drugs. We note the tension between an identified need and the question of how to control costs. Many of the elderly need drugs and cannot afford them. However, we see that when state programs provide these benefits, costs are sometimes sizable and fast-growing. The substantial deductions and copayments in H.R. 2470 and S. 1127 are intended to address this issue. We hope that the facts that we have provided will be useful to you.

Views of Agency Officials

Because of the time, we did not obtain official agency comments on this letter. Unless you plan to publicly announce its contents earlier, we do not plan to distribute it for 30 days.

If you have any questions, please call me at (202) 275-1854 or Carl Wisler at (202) 275-3092.

Sincerely,

Eleanor Chelimsky
Director

State Medicaid Coverage

State	Copayment	Formulary	Restrictions		
			Excludes drugs	Restricts drugs to specific illness	Other major restrictions
Alabama	$0.50-$3.00	yes		yes	
Alaska	No drug program	[a]			
Arizona	[b]	[a]			
Arkansas	0	no	yes		4 Rx/month
California	$1.00 (optional)	yes		yes	
Colorado	$0.50	no	yes		
Connecticut	0	no	yes		
Delaware	0	no	yes		
District of Columbia	$0.50	no	yes		
Florida	0	no	yes		$22/month
Georgia	0	yes		yes	6 Rx/month
Hawaii	0	yes		yes	
Idaho	0	no	yes		
Illinois	0	yes		yes	
Indiana	0	no	yes		
Iowa	$1.00	no	yes		
Kansas	$1.00	yes		yes	
Kentucky	0	yes		yes	
Louisiana	0	no	yes		
Maine	$0.50	no	yes		
Maryland	$0.50 (for state funded)	no	yes		
Massachusetts	0	no	yes		
Michigan	$0.50	yes		yes	
Minnesota	0	yes		yes	
Mississippi	$1.00	yes		yes	4 Rx/month
Missouri	$0.50-$2.00	yes		yes	5 Rx/month
Montana	$0.50	no			
Nebraska	0	no	yes		
Nevada	$1.00	no	yes		3 Rx/month
New Hampshire	$0.75	no	yes		
New Jersey	0	no	yes		
New Mexico	0	no	yes		
New York	0	yes		yes	
North Carolina	$0.50	no			6 Rx/month
North Dakota	0	no			
Ohio	0	yes		yes	
Oklahoma	0	yes		yes	3 Rx/month

State	Copayment	Formulary	Restrictions		
			Excludes drugs	Restricts drugs to specific illness	Other major restrictions
Oregon	0	no	yes		
Pennsylvania	$0.50	no	yes		
Rhode Island	0	yes		yes	
South Carolina	$0.50	no	yes		3 Rx/month
South Dakota	$1.00	yes		yes	
Tennessee	0	yes		yes	7 Rx/month
Texas	0	no			
Utah	0	no	yes		
Vermont	$1.00	no	yes		
Virginia	$0.50-$1.00	no	yes		
Washington	0	yes		yes	
West Virginia	$0.50-$1.00	yes		yes	
Wisconsin	$0.50	no	yes		
Wyoming	No drug program	[a]			

[a]Not applicable.

[b]There is no copayment, depending on a formula under an Arizona Health Care Cost Containment System capitation plan.

Source: Joseph A. Cislowski, "Coverage of Outpatient Prescription Drugs," report for the Senate Finance Committee, Congressional Research Service, Washington, D.C., June 15, 1987.

State Prescription Drug Programs

State	Year enacted	Age	Maximum income
Maine	1977	62+	$6,600 single, $7,900 couple
New Jersey	1977	65+	$13,650 single, $16,750 couple
Maryland	1979	None	$6,100 single, $11,950 family of 10
Delaware[c]	1982	65+	$7,500 single, $10,600 couple
Pennsylvania	1984	65+	$12,000 single, $15,000 couple
Illinois	1985	65+	$14,000 household
Rhode Island	1985	65+	$9,000 single, $12,000 couple
Connecticut	1986	65+	$13,300 single, $16,000 couple
New York	1986	65+	$9,000 single, $12,000 couple, low income; $15,000 single, $20,000 couple, medium income

Program characteristics			Annual cost (million)	Number of recipients	Total population 65+	Recipients as % of population 65+
Copayment	Drugs covered	Funding				
$2.00	Most Rx for heart, blood pressure, diabetes, and antiarthritic drugs	General fund	$1.4	25,000	152,000	16%
$2.00	All Rx, insulin, and test materials	About 2/3 general fund and 1/3 casino funds	$96.1	239,259	942,000	25%
$1.00	All Rx and Medicaid over-the-counter	General fund	$5.3	15,088[a]	447,000	[b]
10% of cost	All Rx and insulin	Du Pont de Nemours Foundation	$1.3	10,000[d]	67,000	15%
$4.00	All Rx for 30-day supply or 100 doses	Lottery	$100.0	446,622	1,646,000	27%
[e]	Cardiovascular, diabetes, and antiarthritic drugs	General fund	About $13.4	56,356	1,320,000	4%
40% of cost	Rx for specific categories of disease	General fund	$2.3[f]	12,700	138,000	9%
$4.00	All Rx	General fund	$13.0	31,852	407,000	8%
[g]	All Rx	General fund	Projected $150.0	470,000[h]	2,254,000	21%

[a]Average monthly enrollment in fiscal year 1987.

[b]Percentage not calculated since the program serves all age groups and not just the elderly.

[c]Not a vendor drug program; all prescriptions are dispensed through the Nemours Memorial Health Clinic, Wilmington, Delaware.

[d]About 6,500 people are active in the program at any one time; 10,000 were enrolled in 1987.

[e]No copayment but an $80 annual fee.

[f]Total costs for the first 21 months of the program, including administrative costs.

[g]About 40 percent of cost plus a quarterly registration fee or an annual premium related to income.

[h]An estimated 1.2 million are eligible.

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